Complete Summary

GUIDELINE TITLE

Emergency contraception.

BIBLIOGRAPHIC SOURCE(S)

American College of Obstetricians and Gynecologists (ACOG). Emergency contraception. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2005 Dec. 10 p. (ACOG practice bulletin; no. 69). [86 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Emergency oral contraception. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2001 Mar. 8 p. (ACOG practice bulletin; no. 25). [48 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Unintended pregnancy resulting from unprotected or inadequately protected sexual intercourse

GUIDELINE CATEGORY

Counseling
Management

CLINICAL SPECIALTY

Obstetrics and Gynecology
Pharmacology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To aid practitioners in making decisions about appropriate obstetric and gynecologic care
- To present evidence regarding the safety, efficacy, risks, and benefits of the use of emergency contraception including progestin-only, combined oral contraceptives, and intrauterine devices

TARGET POPULATION

Women who had unprotected or inadequately protected sexual intercourse within the previous 120 hours who do not desire pregnancy

INTERVENTIONS AND PRACTICES CONSIDERED

1. Emergency oral contraception including levonorgestrel-only (preference) and combination estrogen-progestin regimen. Refer to Table 1 in the original guideline document for detailed information on the formulation and dosage of common oral contraceptives used as emergency contraception.
2. Antiemetic agent to be taken 1 hour before the first dose of combined estrogen-progestin regimen
3. Counseling patients regarding effective contraceptive methods at the time emergency contraception is prescribed
4. Offering patients an advance prescription for emergency contraception during a routine gynecologic visit
5. Evaluating patients for pregnancy if menses are delayed by a week or more after expected time or if lower abdominal pain or persistent irregular bleeding develops.

MAJOR OUTCOMES CONSIDERED

Incidence of unintended pregnancy

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The MEDLINE database, the Cochrane Library, and American College of Obstetricians and Gynecologists' (ACOG's) own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 1985 and January 2005. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document.

Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I Evidence obtained from at least one properly designed randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Analysis of available evidence was given priority in formulating recommendations. When reliable research was not available, expert opinions from obstetrician-gynecologists were used. See also the "Rating Scheme for the Strength of Recommendations" field regarding Grade C recommendations.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A - Recommendations are based on good and consistent scientific evidence.

Level B - Recommendations are based on limited or inconsistent scientific evidence.

Level C - Recommendations are based primarily on consensus and expert opinion.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Practice Bulletins are validated by two internal clinical review panels composed of practicing obstetrician-gynecologists, generalists and subspecialists. The final guidelines are also reviewed and approved by the American College of Obstetricians and Gynecologists (ACOG) Executive Board.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (I-III) and levels of recommendations (A-C) are defined at the end of "Major Recommendations" field.

The following recommendations are based on good and consistent scientific evidence (Level A):

- Emergency contraception should be offered or made available to women who have had unprotected or inadequately protected sexual intercourse and who do not desire pregnancy.
- The levonorgestrel-only regimen is more effective and is associated with less nausea and vomiting; therefore, if available, it should be used in preference to the combined estrogen-progestin regimen.
- The 1.5-mg levonorgestrel-only regimen can be taken as a single dose.
- The two 0.75-mg doses of the levonorgestrel-only regimen are equally effective if taken 12-24 hours apart.
- To reduce the chance of nausea with the combined estrogen-progestin regimen, an antiemetic agent may be taken 1 hour before the first emergency contraception dose.
- Prescription or provision of emergency contraception in advance of need can increase availability and use.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Treatment with emergency contraception should be initiated as soon as possible after unprotected or inadequately protected intercourse to maximize efficacy.
- Emergency contraception should be made available to patients who request it up to 120 hours after unprotected intercourse.
- No clinician examination or pregnancy testing is necessary before provision or prescription of emergency contraception.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- No data specifically examine the risk of using hormonal methods of emergency contraception among women with contraindications to the use of conventional oral contraceptive preparations; nevertheless, emergency contraception may be made available to such women.
- Clinical evaluation is indicated for women who have used emergency contraception if menses are delayed by a week or more after the expected time or if lower abdominal pain or persistent irregular bleeding develops.
- Information regarding effective contraceptive methods should be made available either at the time emergency contraception is prescribed or at some convenient time thereafter.
- Emergency contraception may be used even if the woman has used it before, even within the same menstrual cycle.

Definitions:

Grades of Evidence

I Evidence obtained from at least one properly designed randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

Levels of Recommendation

Level A - Recommendations are based on good and consistent scientific evidence.

Level B - Recommendations are based on limited or inconsistent scientific evidence.

Level C - Recommendations are based primarily on consensus and expert opinion.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Overall Benefits

Increasing emergency contraception awareness, knowledge, and access are important priorities in the effort to reduce the incidence of unintended pregnancy.

Specific Benefits

Estimates based on combined data from two studies show a reduced relative risk of pregnancy (0.51, 95% confidence interval, 0.31-0.83) with the levonorgestrel-only regimen.

POTENTIAL HARMS

Adverse Effects of Contraceptive Agents

- Short term side effects of emergency contraception include:
  - Nausea and vomiting
  - Irregular bleeding
  - Other side effects including breast tenderness, abdominal pain, dizziness, headache, and fatigue

CONTRAINDICATIONS

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Although existing pregnancy is not a contraindication for emergency contraception use in terms of risk of adverse effects, emergency contraception is not indicated in women with confirmed pregnancy because it will have no effect.

QUALIFYING STATEMENTS

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- These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.
- Some emergency contraception studies have excluded women with specific contraindications to oral contraceptives, but no evidence demonstrates that emergency contraception is unsafe for women with these contraindications or for those with any particular medical conditions.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 Mar (revised 2005 Dec)

GUIDELINE DEVELOPER(S)

American College of Obstetricians and Gynecologists - Medical Specialty Society

SOURCE(S) OF FUNDING

American College of Obstetricians and Gynecologists (ACOG)

GUIDELINE COMMITTEE

American College of Obstetricians and Gynecologists (ACOG) Committee on Practice Bulletins-Gynecology

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: None available

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 4500, Kearneysville, WV 25430-4500; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on September 22, 2004. The information was verified by the guideline developer on December 9, 2004. This NGC summary was updated by ECRI on April 20, 2006.

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